STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R0000	This visit was for a State Residential Licensure Survey. Survey dates: October 22, 23, 24 & 25, 2012 Facility number: 003984 Provider number: 003984 AIM number: N/A Survey team: Marcy Smith RN TC Dinah Jones RN Patti Allen BSW [October 22, 23 & 25, 2012] Census bed type: Residential: 22 Total: 22 Census payor type: Other: 22 Total: 22 Sample: 8 These State Residential Findings are in accordance with 410 IAC 16.2. Quality review completed 10/29/12 Cathy Emswiller RN	R0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0055	410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on observation, record review and interview, the facility failed to ensure confidential information about a resident was discussed in a location where it could not be overheard by visitors and other residents. (Resident # 2) Findings include: The record of Resident #2 was reviewed on 10/25/12 at 11:00 a.m. She was admitted to the facility on 8/31/12 with the diagnosis of brain tumor and was hospitalized 10/23/12 due to her deteriorating condition. Her initial Assessment and Negotiated Service Plan," dated 8/17/12, indicated she was at a Level 1 and needed "no services." A mini mental assessment completed by a nurse, dated 8/6/12, indicated "Impairment." A mini mental exam dated 10/16/12, indicated "Severe impairment." On 10/24/12 at 11:20 a.m. an	R0055	**Citation #1 R 055 410 IAC 16.2-5-1.2(y) (1-4) Residents' Rights - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No other residents were found to be affected**. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Residence Director reviewed community practices regarding disclosure of resident health care information and designated an area within the community for disclosure with appropriate entities. The Residence Director re-educated staff as to our policy and procedure regarding resident confidentiality to ensure continued compliance. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The staff were re-educated to the Indiana State	12/15/2012

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	observation was made of the Residence Marketing Director, the Wellness Director and Resident #2's son sitting at a table in the central lounge area having a conversation. From a distance of approximately 45 feet (Library/TV Room to the table where the conference was taking place) the words "hospice," "hospital," and "discharge" were overheard. From a distance of approximately 15 feet (chair in lounge to table) the words "I doubt she'll ever be back to eating in the dining room," "Hospice," " Level 1 to Level 4," and "can't afford" were overheard. An activity was taking place approximately 18 feet from the table where the conference was being held. Residents #19, 13, 12, 1, 16, 22, and 21 were participating in the activity. Resident #8 walked by the table, approximately 4 feet away, at 11:30 a.m. During in interview with the Residence Marketing Director on 10/25/12 at 9:50 a.m. he indicated it was not "the norm" to hold family conferences in the central lounge. He indicated "I usually have conferences in my office."		ruling R 055 410 IAC 16.2-5-1.2(y) (1-4) Resident Rights and our policy and procedure regarding resident confidentiality. The Residence Director and/or Designee will be responsible for ensuring resident care conferences are held in a designated area within the community that preserves the resident's dignity and confidentiality pertaining to his or her medical records and protected health care information. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will be responsible for monitoring resident confidentiality through weekly rounds of the community to ensure continued compliance with the above referenced regulation for a period of 6 months. Findings will be reviewed and corrected through the Worthington House QA process. A Quality Assurance meeting will be held after six months to determine the need for the ongoing monitoring plan. Findings suggestive of compliance result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon results of random reviews that indicate no additional areas of concern concerning the above referenced regulatory criteria. The	

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			Regional Director of Quality and Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance. **By what date will the systemic changes be completed?** 12/15/12	

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R0120	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview the facility failed to provide the required 6	R0120	**Citation #2 R 120 410 IAC 16.2-5-1.4(e) (1-3) Personnel - Noncompliance What**	12/15/2012

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	hours of dementia training within 6 months of hire and 3 hours of required annual training thereafter, for 4 of 5 employee files reviewed for dementia training. (Personal Service Assistant #6, Housekeeper #7, Dietary Services Coordinator and Licensed Practical Nurse #8) Findings include: The employee file of PSA (Personal Service Assistant) #6, hired 12/12/11, received 1 hour of dementia training on 5/9/12 and 2 hours of training on 7/26/12. The employee file of Housekeeper #7, hired 2/26/04, indicated she received 0 hours of dementia training. The employee file of the DSC (Dietary Services Coordinator), indicated she was hired 8/28/10 and had received 0 hours of dementia training. The employee file of LPN (Licensed Practical Nurse) #8, hired 8/28/11, indicated she had received 1 hour of dementia training on 8/9/12. An interview with Residence Director #2 on 10/24/12 at 10:30 AM, indicted she had provided all documentation available.		**corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and Residence Director were re-educated to the Indiana State Ruling 410 IAC 16.2-5-1.4(e)(1-3) Personnel. The Wellness Director and/or Designee will be responsible for monitoring employee in-service records to ensure continued compliance with the above referenced regulation. A spreadsheet will be created identifying each employee, their required training, and satisfaction of that training through scheduled in-service education programs. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform random monthly audits of employee files to ensure	

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	She indicated she was aware all employees are required to receive 6 hours of dementia training within the first 6 months of hire and 3 hours of dementia training annually thereafter. Two additional records entitled, "Inservice Training Attendance Log", were provided by Residence Director #2 on 10/25/12 at 9:40 AM verifying the above findings.		Alzheimer/Dementia trainings are completed in accordance with the Indiana state regulation 410 IAC 16.2-5-1.4(e)(1-3) Personnel. Audits will be completed and reviewed for a period of 6 months in order to determine the frequency of the ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon results of random reviews that indicate no additional areas of concern concerning the above referenced regulatory criteria. The Regional Director of Quality and Care Management and/or Designee will review the employee training spreadsheet monthly for 6 months then quarterly thereafter to ensure continued compliance. **By what date will the systemic changes be completed?** 12/15/12	

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R0154	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview the facility failed to ensure the kitchen and kitchen appliances used to store and prepare food were clean or maintained in a sanitary condition This had the potential to affect 22 residents who received meals from the kitchen in the facility population of 22. Findings Include: During the tour of the kitchen and observation of noon meal preparation on 10/22/12 at 10:50 a.m., with dietary staff #5 the following were observed: 1) The stove hood had accumulation of greasy film gather and hanging down in strands in the right side upper corner over the right side burners where noon meal uncovered food was cooking. 2) Behind stove there was a heavy accumulation of dirt, dust, greasy film and debris.	R0154	**Citation #3 R 154 410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. The stove hood and the area behind the stove were cleaned. The refrigeration units were cleaned and thawed meat was placed on a tray. Food items were covered and dated per Indiana state regulation. The ceiling vents, kitchen walls, kitchen corners, cabinet droors, door frames, and ceiling located in the kitchen were cleaned and painted. The dry food storage area was also cleaned by staff. Items stored in the dry food area were placed no less than six inches off the floor. The walls and corners of the kitchen were cleaned and painted. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Residence Director conducted rounds of the Residence to ensure compliance	12/15/2012

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	3) The first Delfield refrigeration units had a large kettle uncovered not dated with a hard grease film covering the substance inside the kettle sitting on second shelf. The bottom shelf had meat thawing with a red/brownish dry substance, the meat was just laying on the shelf. The second unit had accumulation of dry food and crumbs on the bottom shelf. The third unit on the fist shelf on the back of the unit was a large area of a smeared red substance. Interview with dietary staff # 5 following the refrigeration observation, she indicated the meat should have been on tray and the kettle should have been covered, dated, and labeled. 4) There was four ceiling vents located between the stove and the food prep table covered with a heavy accumulation of greasy film,dirt, and dust hanging down and extending to the ceiling. There was two more ceiling vents located between the three compartment sink, dishwasher and where clean dishes were stored covered with a heavy accumulation of greasy film,dirt, and dust hanging down and extending to the ceiling. 5) In the dry food storage there was flour in the floor near the flour bin.		with R 154 410 IAC 16.2-5-1.5 (k) Sanitation and Safety Standards. No residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and dietary staff were re-educated to our policy and procedure regarding kitchen sanitation and safety guidelines via our Registered Dietician through consultation and/or webinar. The Residence Director and-staff were re-educated to kitchen safety and sanitation practices regarding donning of hairnets when entering food prep areas. The cleaning schedule for dietary staff and maintenance have been updated to ensure kitchen areas are clean and maintained in a state of good repair. The Residence Director and/or Designee will be responsible for ensuring compliance with R154 410 IAC 16.2-5-5.1(k) Sanitation and Safety Standards. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will perform random weekly audits of kitchen sanitation using the Kitchen Sanitation Checklist to ensure continued compliance for a period of six months. Findings will be	

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	On the floor in the flour was individual packets of crackers and 1/4 bag of pasta, couple of potatoes under the shelf. 6) There was a built up of dirt and debris along the walls and corners through out the kitchen. Five of five door frames located in the kitchen were soiled and had a built up dirt dust.. 7) During meal prep and service CNA # 4 came in and out kitchen, in food prep area with out hair cover. On 10/25/12 at 11:05 a.m. during noon meal prep interview with Dietary Manager she indicated everyone entering the kitchen should have hair covering. She indicated at this time this had the potential to affect 22 residents who received meals from the facility kitchen.		reviewed through the Worthington House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon results of random reviews that indicate no additional areas of concern concerning the above referenced regulatory criteria. The Regional Director of Quality and Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance. **By what date will the systemic changes be completed?** 12/15/12	

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R0214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure a prospective resident was evaluated prior to his admission, according to facility policy, for 1 of 7 residents reviewed for preadmission evaluations in a sample of 8. (Resident #24) Findings include: The record of Resident #24 was reviewed on 10/22/12 at 1:30 p.m. Diagnoses for Resident #24 included, but were not limited to, dementia and high blood pressure. A "Resident Handbook," received from the Regional Director of Operations on 10/24/12 at 11:00 a.m., dated 07/2006, indicated "...Resident Criteria...The Residence was designed to care for older adults...who, due to a physical impairment or minor memory deficit, need help with their daily routine..."	R0214	**Citation #4 R 214 410 IAC 16.2-5-2(a) Evaluation - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident #24 no longer resides at Worthington House. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Wellness Director and/or Designee conducted a review of current residents and recent admissions to Worthington House to ensure compliance with the above referenced citation. No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to our policy and procedure regarding pre-admission evaluations for potential new residents. The	12/15/2012

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	During an interview with the Wellness Director and the Regional Nurse Consultant on 10/23/12 at 1:40 p.m., they indicated they "typically" go to a facility or home or make an appointment for the family to bring a prospective resident into the facility to do an evaluation prior to admission. They indicated it was facility policy to always assess a prospective resident's mobility, elopement risk and to do a mini-mental exam. During an interview with the Regional Director of Operations and the Wellness Director on 10/24/12 at 2:10 p.m., the Regional Director of Operations indicated it is "company policy" to always do face to face evaluations prior to admission. The evaluation includes a needs assessment, a mini-mental exam and an elopement risk assessment. She indicated any elopement risk that scores over "40" has to go to the Regional Nurse Consultant for approval. The Wellness Director at this time indicated a low score on the mini-mental exam must also go to the Regional Nurse Consultant for approval. Resident #24 was admitted to the facility on 10/1/12.		Wellness Director and/or Designee will be responsible for ensuring that pre-admission assessments are accurate and up to date per our policy and procedure. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Residence Director will audit pre-admission evaluations for completion and accuracy per our policy and procedure. The Regional Director of Quality Care Management will perform random monthly audits of pre-admission evaluations to ensure continued compliance for a period of 6 months. Findings will be reviewed through the Worthington House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon results of random reviews that indicate no additional areas of concern concerning the above referenced regulatory criteria. The Regional Director of Quality and Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance. **By what date will the systemic changes be completed?** 12/15/12	

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	A "Service Assessment/Negotiated Service Plan," dated 9/27/12, indicated Resident #24 needed the facility to administer his medications and needed assistance with eating. No other needs were identified. This Service Assessment/Negotiated Service Plan did not indicate who performed the assessment or how the information was obtained, i.e. from the prospective resident or family member. During an interview with the Regional Director of Operations and the Wellness Director on 10/24/12 at 2:10 p.m., the Wellness Director indicated the Residence Marketing Director had told him Resident #24 was not available for a face to face evaluation because the resident's daughter worked. He indicated he had done the 9/27/12 pre-admission Service Assessment/Negotiated Service Plan over the telephone with the resident's daughter. The Regional Director of Operations and the Wellness Director indicated the mini-mental exam and the elopement risk had not been done until after the resident had been admitted to the facility. A Folstein Mini Mental Status Examination, dated 10/1/12 after			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORTHINGTON HOUSE	10799 ALLIANCE DR CAMBY, IN 46113

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	Resident #24 had arrived at the facility and was admitted, indicated a score of "1" out of a possible 30. It indicated a score of "10 or less severe deficit." It did not indicate who performed the examination. An "Elopement Risk Assessment," signed by the Wellness Director, dated 10/1/12 after Resident #24 had arrived at the facility and was admitted, indicated a score of "48." It indicated a score of "40 and above High risk for elopement. R [egional] D[irector] O[perations], R [egional] N[urse] C[onsultant] and VP (Vice President) of Clinical Services notification required." After Resident #24's admission to the facility on 10/1/12, nurses' notes indicated the following: 10/1/12 1930 "very confused and unsteady...tries to ambulate [without] help...saw resident in courtyard & had fallen ..." 10/2/12 at 1900 "cont[inues] to get up [without] assistance staff constantly reminding resident & to try & keep resident [with] someone at all times...very unsteady" 10/3/12 l345 "Confused...Staff 1 on 1...unsteady" 10/6 8:00 a.m. "...fall at			

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	approx[imately] 1115 p...EMS (emergency medical service) here to assess...remains in residence..." 10/7/12 7:50 a.m. "entered residents room @ approx[imately] 1020 pm on 10/6/12 & resident laying in fetal position on L[eft] side...blood on bed sheets & pillowcase & unresponsive. 911 called...transported to [name of hospital]...spoke with POA [power of attorney]...said mass was identified on cerebellum..." During an interview with the Regional Director of Operations and the Wellness Director on 10/24/12 at 2:10 p.m. they indicated a face to face preadmission evaluation, mini mental exam and elopement risk should have been done for Resident #24 prior to his admission to the facility on 10/1/12. They indicated if the evaluations had been done face to face and prior to 10/1/12, the facility might have determined they were not able to meet Resident #24's needs.			

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R0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on record review, observation and interview, the facility failed to ensure food was prepared and served in a sanitary manner for 1 of 2 kitchen observations and 3 of 3 dining room observations. This had the potential to affect 22 of the 22 residents residing in the facility. Findings include: 1. During 3 observations of staff serving food in the facility dining room, the following occurred: a) On 10/22/12 at 12:20 p.m. Certified Nursing Assistant (CNA) #1 was observed picking up Resident #1's roll with her bare hands in order to spread butter on the roll. b) On 10/23/12 at 12:10 p.m. CNA #1 was again observed picking up Resident #1's roll with her bare hands in order to spread butter on the roll. c) On 10/25/12 at 12:10 p.m. CNA #1 was observed holding Resident #3's baked potato with her bare hand in order to cut it up.	R0273	**Citation #5 R 273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Residence Director conducted rounds of the Residence to ensure compliance with R 154 410 IAC 16.2-5-1.5 (k) Sanitation and Safety Standards. No residents were found to be affected. No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and dietary staff were re-educated to our policy and procedure regarding kitchen sanitation and safety guidelines via our Registered Dietician through consultation and/or webinar. The Dining Services	12/15/2012

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	A facility policy dated 6/2008, titled "Safe Food Handling: Reasons and Methods," received from Resident Director #1 on 10/24/12 at 10:20 a.m. indicated "...14...During meal service ALL food items must be handled with utensils or gloved hands..." 2) During an observation of meal preparation in the kitchen on 10/22/12 at 12:10 p.m., dietary staff #5 handled the rolls with a gloved hand that she had opened the refrigerator, cabinets, and drawers with out changing her gloves or washing her hands. On 10/25/12 at 11:05 a.m. during noon meal prep interview with Dietary Manager she indicated the dietary staff should have changed gloves and washed her hands and used tongs.		Coordinator and/or Designee will be responsible for ensuring that food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling standards to ensure compliance with R237 410 IAC 16.2-5-5.1(f) Food and Nutritional Services. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will perform random daily audits of food preparation and serving during meals to ensure continued compliance for a period of 6 months. Findings will be reviewed through our Worthington House QA process after 6 months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon results of random reviews that indicate no additional areas of concern concerning the above referenced regulatory criteria. The Regional Director of Quality and Care Management and/or Designee will complete Quarterly site visits of community to ensure continued compliance. **By what date will the systemic changes be completed?** 12/15/12	

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R0349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure documentation of insulin administration was done in a manner which indicated who gave the insulin for 1 of 7 records reviewed for complete documentation in clinical records in a sample of 8. (Resident #1) Findings include: The record of Resident #1 was reviewed on 10/23/12 at 10:00 a.m. Diagnoses for Resident #1 included, but were not limited to, diabetes mellitus. A recapitulated physician's order for October, 2012, with an original date of 6/20/11, indicated Resident #1 was to have accuchecks (a finger stick blood test to measure blood sugar) done 3 times per day.	R0349	**Citation #6 R 349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records- Noncompliance What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Staff will document Resident #1's insulin administration on the Medication Administration Record upon administration. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** The Wellness Director conducted a review of the records of residents receiving insulin to ensure appropriate documentation of insulin administration is documented upon the Medication Administration Record. No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the**	12/15/2012

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	A recapitulated physician's order for October, 2012, with an original date of 11/19/12 indicated Resident #1 was to receive Novolog insulin injections per a sliding scale dependent on the results of the above accuchecks. Review of a "Blood Glucose Monitoring Tool" for August, 2012, for Resident #1, indicated the accuchecks were done and Novolog insulin given as ordered but did not indicate who gave Resident #1 the insulin. Review of an August 2012 Medication Administration Record for Resident #1 indicated "See Flowsheet" next to the sliding scale insulin columns. It did not indicate who administered the sliding scale insulin. During an interview with the Wellness Director on 10/23/12 at 2:50 p.m. he indicated the nurses should have signed their initials when they gave the insulin., A facility policy, dated 6/2008, titled "General Procedures for Providing for the Administration of Subcutaneous Insulin) Injection," received from the		**deficient practice does not recur?** The Wellness Director and Licensed Nursing staff were re-educated to our policy and procedure regarding administration of subcutaneous insulin administration. The Wellness Director and/or Designee will be responsible for ensuring that the documentation required for insulin administration is documented upon the Medication Administration Record as referenced within our policy and procedure and Indiana state regulation R349 410 IAC 16.2-5-8.1(a)(1-4) Clinical Records. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform weekly audits of the Medication Administration Record to ensure continued compliance for a period of six months. Findings will be reviewed through the Worthington House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. Cessation of the monitoring plan will be based upon results of random reviews that indicate no additional areas of concern concerning the above referenced regulatory criteria. The Regional Director of	

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	Regional Consultant Nurse on 10/23/12 at 3:05 p.m. indicated "...8. Record the time and site (if so instructed) by initialing on the medication/treatment record on the appropriate day..."		Quality and Care Management and/or Designee will also perform quarterly random on site reviews of the Medication Administration Records to ensure continued compliance. **By what date will the systemic changes be completed?** 12/15/12	